New Jersey Department of Health and Senior Services
HIV Home Care Program

PHYSICIAN CERTIFICATION AND PLAN OF CARE

Name of Client	Certification Period From: To: *(Recertification every 60 Days)*
Diagnosis(es)	

The service plan developed by the case manager for the above-named client includes the following services (indicated by a check mark) which are covered by the HIV Home Care Program:

CASE MANAGEMENT

- ☐ Case Management: Initial and Monthly

PARAPROFESSIONAL CARE

- ☐ Homemaker/Home Health Aide Services: _____ hours/day _____ days/week
- ☐ Personal Care Attendant: _____ hours/day _____ days/week

PROFESSIONAL CARE

- ☐ Routine Nursing: Number of visits/week _____
- ☐ Occupational Therapy: Evaluation and/or number of visits/week _____
- ☐ Physical Therapy: Evaluation and/or number of visits/week _____
- ☐ Speech Therapy: Evaluation and/or number of visits/week _____
- ☐ Medical Social worker: Evaluation and/or number of visits/week _____

SPECIALIZED CARE

- ☐ Intravenous Drug Therapy and IV Prescription Drugs: Number of days/week _____
  Specific Drugs: _____
- ☐ Respiratory Therapy: Number of visits/week _____
- ☐ Routine Diagnostic/Monitoring Tests: Number of days/week _____
  Specific Test(s): _____

OTHER SERVICES

- ☐ Medical Day Care: Number of days/week _____
- ☐ Durable Medical Equipment, Specifically: _____
  _____

Name of Physician (Print)

Address

Signature	Date

If the service plan is medically appropriate and directly related to this client's HIV infection, please sign and return this form to:

Case Manager: _____
Agency Name: _____
Address: _____
_____
Telephone No.: _____